CHAPTER NO. 948

HOUSE BILL NO. 3018

By Representative Walley

Substituted for: Senate Bill No. 3091

By Senators Elsea, Clabough

AN ACT to amend Title 56, relative to the enactment of the Tennessee Prepaid Limited Health Service Organization Act of 2000.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, is hereby amended by adding a new Chapter and Part to be entitled as the "Tennessee Prepaid Limited Health Service Organization Act of 2000."

SECTION 2. Definitions.

As used in this act, the term:

(1) "Capitation" means the fixed amount paid by a prepaid limited health service organization to a health care provider under contract with the prepaid limited health service organization in exchange for the rendering of covered limited health services.

(2) "Commissioner" means the Commissioner of Commerce and Insurance.

(3) "Department" means the Department of Commerce and Insurance.

(4) "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract, or any other evidence of coverage, with a health maintenance organization, licensed pursuant to Title 56, Chapter 32 or a contract with a state or federal agency.

(5) "Evidence of coverage" means the certificate, agreement, membership card, or contract issued pursuant to this act setting forth the coverage to which an enrollee is entitled through a health maintenance organization licensed pursuant to Title 56, Chapter 32 or a state or federal agency.

(6) "Insolvent" means that all the statutory assets of the prepaid limited health service organization, if made immediately available, would not be sufficient to discharge all of its statutory liabilities or that the prepaid limited health service organization is unable to pay its debts as they become due in the usual course of business.

(7) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, and pharmaceutical services. "Limited health service" does not include inpatient, hospital surgical services, or emergency services except as such services are provided incident to the limited health

services set forth in this subsection. However, “limited health service” does not exclude inpatient mental health or inpatient substance abuse services.

(8) "Prepaid limited health service contract" means any contract entered into by a prepaid limited health service organization with a health maintenance organization or a state or federal agency to provide limited health services in exchange for a prepaid per capita or prepaid aggregate fixed sum.

(9) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment from a health maintenance organization or a state or federal agency, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. A Prepaid limited health service organization may not contract with individuals, but only through a health maintenance organization or a state or federal agency. This shall not limit the organization from contracting with providers to provide contracted services. Prepaid limited health service organization does not include:

(a) An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service;

(b) A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer, or a self-insurance plan; or

(c) Any person who, in exchange for fees, dues, charges or other consideration, provides access to a limited health service provider without assuming any responsibility for payment for the limited health service or any portion thereof.

(10) "Provider" means, but is not limited to, any physician, dentist, health facility, or other person or institution which is duly licensed in this state to deliver limited health services.

(11) "Qualified independent actuary" means an actuary who is a member of the American Academy of Actuaries or the Society of Actuaries and has experience in establishing rates for limited health services and who has no financial or employment interest in the prepaid limited health service organization.

(12) "Reporting period" means the annual accounting period or fiscal year, or any part thereof, of the prepaid limited health service organization. The calendar year shall be the fiscal year for each such organization.

(13) "Subscriber" means an individual on whose behalf a contract or arrangement has been entered into with a prepaid limited health service organization for health care services or other persons who also receive health care services as a result of the contract.

(14) "Surplus notes" means debt which has been subordinated to all claims of subscribers and general creditors of the organization and the debt instrument shall so state.

(15) "Statutory accounting principles" means generally accepted accounting principles, except as modified by this act.

(16) “Working capital” means current assets minus current liabilities.

SECTION 3. Except as provided in this act, prepaid limited health service organizations are governed by the provisions of this act and are exempt from the Tennessee Insurance Code unless specifically referenced.

SECTION 4. Insurance business not authorized.

Nothing in the Tennessee Insurance Code or this act authorizes any prepaid limited health service organization to transact any insurance business other than that specifically authorized by this act, or otherwise to engage in any other type of insurance unless it is authorized under a certificate of authority issued by the department under the provisions of the Tennessee Insurance Code.

SECTION 5. Certificate of authority required.

A person, corporation, partnership, or other entity may not operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the department pursuant to this act. A political subdivision of this state which is operating an emergency medical services system and offers a prepaid ambulance service plan as a part of its emergency medical services system shall be exempt from the provisions of this act and all other provisions of the Tennessee Insurance Code. An insurer, while authorized to transact health insurance in this state, or a health maintenance organization possessing a valid certificate of authority in this state, or a duly licensed medical and hospital service corporation may also provide services under this act without additional qualification or authority, but shall be otherwise subject to the applicable provisions of this act.

SECTION 6. Application for certificate of authority.

Before any entity may operate a prepaid limited health service organization, it must obtain a certificate of authority from the department. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the department on a form prescribed by the department. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following:

(a) A copy of the applicant's basic organizational document, including the articles of incorporation, articles of association, partnership agreements, trust agreement, or other applicable documents and all amendments to such documents.

(b) A copy of all bylaws, rules, and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10

percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the prepaid limited health service organization, including any possible conflicts of interest.

(d) A complete biographical statement, on forms prescribed by the department, an independent investigation report, with respect to each individual identified under subsection (c).

(e) A statement generally describing the applicant, its facilities and personnel, and the limited health service or services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in subsection (c).

(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees.

(i) A copy of the form of any prepaid limited health service contract which is to be issued to employers, unions, trustees, individuals, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers.

(j) A copy of the applicant's most recent financial statements audited by an independent certified public accountant.

(k) A copy of the applicant's financial plan, including a 3-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed.

(l) A schedule of rates and charges for each contract to be used which contains an opinion from a qualified independent actuary that the rates are not inadequate, excessive, or discriminatory.

(m) A description of the proposed method of marketing.

(n) A description of the subscriber complaint procedures to be established and maintained as required under Section 32 of this act.

(o) A description of how the applicant will comply with Section 38 of this act.

(p) The fee for issuance of a certificate of authority as provided in Section 47 of this act.

(q) Such other information as the department may reasonably require to make the determinations required by this act.

SECTION 7. Issuance of certificate of authority; denial.

(a) Following receipt of an application filed pursuant to Section 7, the department shall review such application and notify the applicant of any deficiencies contained therein. The department shall issue a certificate of authority to an applicant who has filed a completed application in conformity with Section 7, upon payment of the fees specified by Section 47 and upon the department being satisfied that the following conditions are met:

(1) The requirements of Section 7 have been fulfilled.

(2) The entity has met the applicable minimum net worth requirements and working capital requirements as provided under §56-32-212.

(3) The entity furnished evidence of adequate insurance coverage, including, but not limited to, general liability or professional liability coverage, or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing covered services.

(4) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a prepaid limited health service organization in this state at any time during which the department has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.

(5) The entity has demonstrated compliance with Section 39 by obtaining a blanket fidelity bond in the amount of at least $50,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds. All employees handling the funds must be covered by the blanket fidelity bond. However, the fidelity bond need not cover an individual who owns 100 percent of the stock of the organization if such stockholder maintains total control of the organization's financial assets, books and records, and fidelity bond coverage is not available for such individual. An agent licensed under the provisions of the Tennessee Insurance Code may, either directly or indirectly, represent the prepaid limited health service organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any subscriber's contract, or collect or forward any consideration paid by the subscriber to the prepaid limited health service organization. The licensed agent shall not be required to post the bond required by this subsection.

(6) The prepaid limited health service organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

(7) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the department may consider:

(A) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith.

(B) The adequacy of surplus, other sources of funding, and provisions for contingencies.

(C) The manner in which the requirements of Section 38 have been fulfilled.

(8) The agreements with providers for the provision of limited health services contain the provisions required by Section 29.

(9) Any deficiencies identified by the department have been corrected.

(10) All requirements of this chapter have been met.

(b) If the certificate of authority is denied, the department shall notify the applicant and shall specify the reasons for denial in the notice.

SECTION 8. Continued eligibility for certificate of authority.

In order to maintain its eligibility for a certificate of authority, a prepaid limited health service organization must continue to meet all conditions required to be met under this act and the rules adopted thereunder for the initial application for and issuance of its certificate of authority under Sections 7 and 8 of this act.

SECTION 9. Certain entities contracting with state Title XIX Agency.

Any entity licensed under this chapter that provides services solely to Title XIX Program recipients under a contract with the State of Tennessee shall be exempt from Sections 7(1), 13(e) and (k), 14, 15, 18, 24, 28 and 35(5)(A) and (B). Further, the commissioner may by rule exempt such entities from other provisions of this act where determined by the commissioner to be reasonable and appropriate. Such rules shall be promulgated in accordance with Section 55.

SECTION 10. Language used in contracts and advertisements; translations.

All contracts or forms utilized by the prepaid limited health services organization, whether directed to providers or enrollees, shall be written in the English language.

SECTION 11. Language used in contracts and marketing materials.

All prepaid limited health services contracts, marketing materials, and literature must disclose in boldfaced type the name of the organization and disclose that the organization is a prepaid limited health service organization licensed under this chapter.

SECTION 12. Prepaid limited health service contracts.

(a) Any entity issued a certificate of authority and otherwise in compliance with this act may enter into contracts in this state to provide an agreed-upon set of limited health services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum from a health maintenance organization or a state or federal agency.

(1) The department shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:

(A) Is in any respect in violation of, or does not comply with, any provision of this act or rule adopted thereunder.

(B) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(C) Has any title, heading, or other indication of its provisions which is misleading.

(D) Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.

(E) Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

(F) Charges rates that are determined by the department to be inadequate, excessive, or unfairly discriminatory.

(2) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(3) All contracts shall be for a minimum period of 12 months, unless the contract holder requests, in writing, a shorter contract period.

(b) Every prepaid limited health service organization shall provide each subscriber a contract, a certificate, membership card, or member handbook which must clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the prepaid limited health service organization. The contract, certificate, provider listing, or member handbook must also state where and in what manner the health services may be obtained.

(c) The documents provided pursuant to subsection (b) must have a clear and understandable description of the method used by the prepaid limited health service organization for resolving subscriber grievances and must contain the address of the department and the department's toll-free consumer hotline.

(d) All prepaid limited health service coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children will be provided with respect to a pre-enrolled newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth, or adoption pursuant to Tennessee law.

(e) No alteration of any written application for any prepaid limited health services contract may be made by any person other than the applicant without his or her written consent, except that insertions may be made by the prepaid limited health service organization for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(f) No contract may contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to prepaid limited health service organizations.

(g) Each document provided pursuant to subsection (b) must state that emergency services, if any, will be provided to subscribers in emergency situations not permitting treatment through the prepaid limited health service organization providers, without prior notification to and approval of the organization. The prepaid limited health services document must contain a definition of emergency services, describe procedures for determination by the prepaid limited health service organization of whether the services qualify for reimbursement as emergency services, and contain specific examples of what does constitute an emergency.

(h)(1) All prepaid limited health services contracts, certificates, and member handbooks must contain the following provision:

> "Grace Period: This contract has a ___(insert number of days, but not less than 10 days)___-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force."

(2) Paragraph (i)(1) does not apply to certificates or member handbooks delivered to individual subscribers under a group prepaid limited health services contract when the employer who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscriber. However, such required provision applies to the group prepaid limited health services contract.

(i) The contract must clearly disclose the intent of the prepaid limited health service organization as to the applicability or nonapplicability of coverage to preexisting conditions. The contract must also disclose what services are excludable.

(j) All prepaid limited health service organization contracts which provide coverage for a member of the family of the subscriber, must, as to such family member's coverage, provide that coverage, benefits, or services applicable for children will be provided with respect to an adopted child of the subscriber, which child is placed in compliance with Tennessee adoption law, from the moment of placement in the residence of the subscriber. In the case of a newborn child, coverage begins from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child whether or not such agreement is enforceable. However, coverage for such child is not required if the child is not ultimately adopted by the subscriber in compliance with Tennessee adoption law.

(k) Each prepaid limited health service organization shall provide prospective enrollees, upon request, with written information about the terms and conditions of the plan in accordance with subsection (b) to enable prospective enrollees to make informed decisions about accepting a managed-care system of limited health care delivery. All marketing materials printed by the prepaid limited health services organization must contain a notice in boldfaced type which states that the information required under this section is available to prospective enrollees upon request.

(l) Each prepaid limited health service organization shall make available to all subscribers, upon request, a description of the authorization and referral process for services or a description of the process used to analyze the qualifications and credentials of providers under contract with the organization.

SECTION 13. Rates and charges.

(a) The rates charged by any prepaid limited health service organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory. The department may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this section.

(b) In determining whether a rate is in compliance with subsection (a), the department must take into consideration the limited services provided, the method in which the services are provided, and the method of provider payment. This section may not be construed as authorizing the department to establish by rule minimum loss ratios for prepaid limited health service organizations' rates.

SECTION 14. Changes in rates and benefits; material modifications; addition of limited health services.

(a)(1) No prepaid limited health services contract, certificate of coverage, application, enrollment form, rider, endorsement, and applicable rates to be charged may be delivered in this state unless the forms and rates have been filed with the department by or on behalf of the prepaid limited health service organization and have been approved by the department. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. If a prepaid limited health service organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any rate charged for the contract or to change any basic prepaid limited health services contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form renewal certificate, it must file such changes 30 days prior to the effective date of the proposed change. At least 30 days' written notice must be provided to the subscriber before application of any approved change in rates. In the case of a group enrollee, there may be a contractual agreement with the prepaid limited health service organization to have the contract holder provide the required notice to the individual enrollees of the group. Any proposed change must contain information as required by this section.

(2) The prepaid limited health service organization's certification must be prepared by an independent actuary. The chief executive officer of the prepaid limited health service organization must review and sign the certification indicating her or his agreement with its conclusions. Following receipt of notice of any disapproval or withdrawal of approval, no

prepaid limited health service organization may issue or use any form disapproved by the department or as to which the department has withdrawn approval.

(b) If such filings are not disapproved by the department within 30 days of the receipt of complete filings, such filings shall be deemed approved.

SECTION 15. Additional contract contents.

A prepaid limited health services contract may contain additional provisions not inconsistent with this act which are:

(a) Necessary because of the manner in which the organization is constituted or operated in order to state the rights and obligations of the parties to the contract; or

(b) Desired by the organization and neither prohibited by law nor in conflict with any provisions required to be included.

SECTION 16. Genetic information restrictions.

A prepaid limited health service organization must comply with the provisions of §§56-7-2701 et seq.

SECTION 17. Restrictions upon expulsion or refusal to issue or renew contract.

(a) A prepaid limited health service organization may not expel or refuse to renew the coverage of or refuse to enroll any individual member of a subscriber group through a health maintenance organization or a state or federal agency on the basis of the race, color, creed, handicap, marital status, sex, or national origin of the subscriber or individual.

(b) A prepaid limited health service organization may not expel or refuse to renew the coverage of any individual member of a subscriber group through a health maintenance organization or a state or federal agency on the basis of the age or health status of the subscriber or individual.

(c) For group solicitations through a contract with a health maintenance organization, a prepaid limited health service organization may pre-underwrite to determine group acceptability. However, once a contract is issued, a prepaid limited health service organization must provide coverage to all existing enrollees and their dependents, and newly employed enrollees and their dependents who have enrolled within 30 days of eligibility or membership.

(d) Nothing in this section prohibits a prepaid limited health service organization from requiring in its contracts with health maintenance organizations that, as a condition of continued eligibility for membership, dependents of a subscriber upon reaching a specified age convert to a converted contract. Coverage must continue to be provided to handicapped children who are incapable of self-sustaining employment by reason of mental or physical handicap, and substantially dependent upon the enrollee for support and maintenance.

SECTION 18. Charter; bylaw provisions.

No prepaid limited health services contract may contain any provision purporting to make any portion of the articles of incorporation, charter, bylaws, or other organizational

document of the prepaid limited health service organization a part of the contract unless the provision is set forth in full in the contract. Any contract provision in violation of this section is invalid unless the provision operates to the benefit of the subscriber.

SECTION 19. Execution of contracts.

(a) Every prepaid limited health services contract must be executed in the name of and on behalf of the prepaid limited health service organization by its officer, attorney in fact, employee, or representative duly authorized by the organization.

(b) A facsimile signature of any executing individual may be used in lieu of an original signature.

(c) No prepaid limited health services contract which is otherwise valid is rendered invalid by reason of the apparent execution thereof on behalf of the prepaid limited health service organization by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the contract.

SECTION 20. Validity of noncomplying contracts.

(a) Any prepaid limited health services contract rider, endorsement, attachment, or addendum otherwise valid which contains any condition or provision not in compliance with the requirements of this act is not thereby rendered invalid, but must be construed and applied in accordance with such conditions and provisions as they would have applied had such contract, rider, endorsement, attachment, or addendum been in full compliance with this act. If an organization issues or delivers any contract for an amount which exceeds any limitations otherwise provided in this act, such organization is liable to the subscriber or his or her beneficiary for the full amount stated in the contract in addition to any other penalties that may be imposed under this act.

(b) Any prepaid limited health services contract delivered or issued for delivery in this state covering a subscriber, which subscriber pursuant to the provisions of this act the organization may not lawfully cover under the contract, is cancelable at any time by the organization, any provision of the contract to the contrary notwithstanding, and the organization must promptly cancel the contract in accordance with the request of the department therefor. No such illegality or cancellation may be deemed to relieve the organization of any liability incurred by it under the contract while in force or to prohibit the organization from retaining the pro rata earned premium or rate thereon. This subsection does not relieve the organization from any penalty otherwise incurred by the organization under this act for any such violation.

SECTION 21. Construction of contracts.

Every prepaid limited health services contract must be construed according to the entirety of its terms and conditions as set forth in the contract and as amplified, extended, or modified by any application, endorsement, attachment, or addendum.

SECTION 22. Delivery of contract.

Unless delivered upon execution or issuance, a prepaid limited health services contract, certificate of coverage, or member handbook must be mailed or delivered to the health maintenance organization or to the state or federal agency with whom the prepaid limited health

services organization has contracted prior to the effective date of coverage by the prepaid limited health service organization.

SECTION 23. Notice of cancellation of contract.

Except for nonpayment of premium or termination of eligibility, a prepaid limited health service organization may not cancel or otherwise terminate or fail to renew a prepaid limited health services contract without giving the subscriber and the health maintenance organization or state or federal agency with whom it has contracted at least 45 days' notice in writing of the cancellation, termination, or nonrenewal of the contract. The written notice must state the reason or reasons for the cancellation, termination, or nonrenewal. The only reasons for cancellation at such time other than the renewal period shall be as follows:

(a) The subscriber's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the subscriber's continuing participation seriously impairs the organization's ability to provide services to other subscribers.

(b) Fraud or material misrepresentation in applying for or presenting any claim for benefits under the contract.

(c) Misuse of the documents provided as evidence of benefits available pursuant to the contract.

(d) Furnishing to the organization, by the subscriber, incorrect or incomplete information for the purposes of fraudulently obtaining services.

Prior to disenrollment, the organization must make an effort to resolve the problem through the grievance procedure and must determine that the subscriber's behavior is not due to use of the services provided or mental illness. All prepaid limited health services contracts must contain a clause which requires that this notice be given. In the case of a prepaid limited health services contract issued to an employer holding the contract on behalf of the subscriber group, the prepaid limited health service organization may make the notification through the employer, and, if the prepaid limited health service organization elects to take this action through the employer, the organization shall be deemed to have complied with the provisions of this section upon notifying the employer of the requirements of this section and requesting the employer to forward the required notice to all subscribers.

SECTION 24. Construction and relationship with other laws.

(a) No other provision of the insurance code applies to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

(b) Except as provided in this act, the insurance code does not apply to prepaid limited health service organizations certificated under this act. Any person, entity, or prepaid limited health service organization operating without a subsisting certificate of authority in violation of this act or rules adopted thereunder, in addition to being subject to the provisions of this act, is subject to the provisions of the insurance code.

(c) The department is vested with all powers granted to it under the insurance code with respect to the investigation of any violation of this act.

SECTION 25. Acceptable payments.

Each prepaid limited health service organization may accept from a health maintenance organization licensed pursuant to Title 56, Chapter 32 or a state or federal agency payments covering all or part of the cost of contracts entered into between the prepaid limited health service organization and its subscribers.

SECTION 26. Certain words prohibited in name of organization.

(a) No entity certificated as a prepaid limited health service organization, other than a licensed insurer or health maintenance organization insofar as its name is concerned, may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual," or "HMO," or any other words descriptive of the insurance, casualty, HMO, or surety business or deceptively similar to the name or description of any insurance, HMO, or surety corporation doing business in the state.

(b) No person, entity, or health care plan not certificated under the provisions of this act may use in its name, logo, contracts, or literature the phrase "prepaid limited health services contract" or the initials "PLHSC" to imply, directly or indirectly, that it is a prepaid limited health service organization or hold itself out to be a prepaid limited health service organization.

SECTION 27. Extension of benefits.

Every prepaid limited health services contract must provide that termination of the contract by the prepaid limited health service organization is without prejudice to any continuous loss which commenced while the contract was in force. Extension of benefits beyond the period the contract was in force must be until the specific treatment or procedure undertaken upon any subscriber has been completed or for 90 days, whichever is the lesser period of time.

SECTION 28. Provider arrangements.

(a) Whenever a contract exists between a prepaid limited health service organization and a provider, and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber who is in good standing, the prepaid limited health service organization is liable for such fee or fees rather than the subscriber, and the contract must so state.

(b) No subscriber, who is in good standing, of a prepaid limited health service organization is liable to any provider of health care services for any services covered by the prepaid limited health service organization.

(c) No provider of prepaid limited health care services or any representative of such provider may collect or attempt to collect from a subscriber any money for services covered by a prepaid limited health service organization, and no provider or representative of such provider may maintain any action against a subscriber of a prepaid limited health service organization to collect money owed to such provider by a prepaid limited health service organization.

(d) Every contract between a prepaid limited health service organization and a provider of health care services must be in writing and must contain a provision that the subscriber is not liable to the provider for any services covered by the subscriber's or enrollee's contract with the prepaid limited health service organization.

(e) The provisions of this section do not apply to the amount of any deductible or copayment which is not covered by the contract, or for services not authorized by the prepaid limited health service organization.

(f)(1) For all provider contracts, the contracts must provide that the provider will provide no less than 90 days' advance written notice to the prepaid limited health service organization before canceling the contract with the prepaid limited health service organization for any reason.

(2) For all provider contracts, the organization shall be responsible for notifying all providers of the provisions of this section and their responsibilities under this part.

(g) Upon receipt by the prepaid limited health service organization of a 90-day cancellation notice, the prepaid limited health service organization may, if requested by the provider, terminate the contract in less than 90 days if the prepaid limited health service organization is not financially impaired or insolvent.

(h) Provider contracts must provide that the prepaid limited health service organization will provide 90 days' advance written notice to the provider before canceling, without cause, the contract with the provider, except where a patient's health is subject to imminent danger or a provider's ability to practice is effectively impaired by an action by another governmental agency.

(j) Every contract between a prepaid limited health service organization and a provider of health care services must contain a provision that if any provision of the agreement is held to be unenforceable or otherwise contrary to any applicable laws, regulations, or rules, such provision shall have no effect and shall be severable without affecting the validity or enforceability of the remaining provisions of this agreement.

(k) A contract between a prepaid limited health service organization and a provider of limited health care services may not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

SECTION 29. Administrative, provider, and management contracts.

(a) The department may require a prepaid limited health service organization to submit any contract for administrative services, contract with a provider physician, contract for management services, or contract with an affiliated entity to the department if the department has information that the prepaid limited health service organization has entered into a contract which requires it to pay a fee which is unreasonably high in relation to the service provided.

(b) After review of a contract, the department may order the prepaid limited health service organization to cancel the contract if it determines that the fees to be paid by the prepaid limited health service organization under the contract are so unreasonably high as compared with similar contracts entered into by the prepaid limited health service organization in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the prepaid limited health service organization.

(c) All contracts for administrative services, management services, or provider services or contracts with affiliated entities, entered into or renewed by a prepaid limited health service organization, must contain a provision that the contract will be canceled upon issuance of an order by the department pursuant to this section.

SECTION 30. Contract providers.

A prepaid limited health service organization that subcontracts with another entity to obtain a network of providers to furnish services to members or enrollees shall guarantee and assure the payment of all contracted amounts agreed to be paid to such providers by that entity or that entity's agent. This subdivision does not preclude the prepaid limited health service organization from seeking reimbursement from the subcontractor for any amounts paid pursuant to this subdivision. Nor does this subdivision prevent the prepaid limited health service organization from asserting any legal defenses to the payment of a provider's claim that were available to the subcontractor. This subdivision shall be effective for all provider claims for services delivered after January 1, 2001.

SECTION 31. Complaint system.

Every prepaid limited health service organization, except such organizations that participate in the TennCare program, shall comply with the provisions of §56-32-210.

SECTION 32. Examination by the department.

The department shall examine the affairs, transactions, accounts, business records, and assets of any prepaid limited health service organization, in the same manner and subject to the same terms and conditions that apply to health maintenance organizations under §56-32-215.

SECTION 33. Assets, liabilities, and investments.

The provisions of §56-32-211 apply in their entirety to determine what assets, liabilities, and investments are acceptable for a prepaid limited health service organization.

SECTION 34. Annual, quarterly, and miscellaneous reports.

(a) Each prepaid limited health service organization must file with the department annually, within 3 months after the end of its fiscal year, a report on the blank specified for health maintenance organizations by the National Association of Insurance Commissioners, verified by the oath of at least two officers covering the preceding calendar year.

(b) In addition to the information contained in the forms provided under subsection (a), the report must also include:

(1) A statutory financial statement of the organization prepared in accordance with statutory accounting principles, including its balance sheet, income statement, and statement of changes in cash flow for the preceding year, certified by an independent certified public accountant, or a consolidated audited financial statement of its parent company prepared on the basis of statutory accounting principles, certified by an independent certified public accountant, attached to which must be consolidating financial statements of the parent company, including the prepaid limited health service organization.

(2) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the prepaid limited health service organization, including any possible conflicts of interest.

(3) The number of prepaid limited health services contracts, issued and outstanding, and the number of prepaid limited health services contracts terminated.

(4) The number and amount of damage claims for medical injury initiated against the prepaid limited health service organization, and if known, any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.

(5) An actuarial report certified by a qualified independent actuary that:

(A) The prepaid limited health service organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for, the payment of obligations of the organization.

(B) The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

(C) Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.

(6) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the department.

(c) Every prepaid limited health service organization which fails to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the department to that effect, the organization's authority to enroll new subscribers or to do business in this state ceases while such default continues. The department may not collect more than $50,000 for each report.

(d) Each authorized prepaid limited health service organization must file a quarterly report for each calendar quarter within 45 days after the end of the quarter. The report shall be in the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall contain:

(1) A financial statement prepared in accordance with statutory accounting principles certified by an independent certified public accountant.

(2) A listing of providers.

(3) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the department.

(e) The department may require monthly reports if the financial condition of the prepaid limited health service organization has deteriorated from previous periods or if the financial condition of the organization is such that it may be hazardous to subscribers if not monitored more frequently.

(f) Each authorized prepaid limited health service organization shall retain an independent certified public accountant, hereinafter referred to as "CPA," who agrees by written contract with the prepaid limited health service organization to comply with the provisions of this act. The contract must state that:

(1) The CPA will provide to the prepaid limited health service organization audited statutory financial statements consistent with this act.

(2) Any determination by the CPA that the prepaid limited health service organization does not meet minimum surplus requirements as set forth in this act will be stated by the CPA, in writing, in the audited financial statement.

(3) The completed workpapers and any written communications between the CPA and the prepaid limited health service organization relating to the audit of the prepaid limited health service organization will be made available for review on a visual-inspection-only basis by the department at the offices of the prepaid limited health service organization, at the department, or at any other reasonable place as mutually agreed between the department and the prepaid limited health service organization. The CPA must retain for review the workpapers and written communications for a period of not less than 6 years.

SECTION 35. Agent licensing.

(a) With respect to a prepaid limited health services contract, a person may not, unless licensed and appointed as a health insurance agent in accordance with the applicable provisions of the insurance code:

(1) Solicit contracts or procure applications; or

(2) Engage or hold herself or himself out as engaging in the business of analyzing or abstracting prepaid limited health services contracts or of counseling or advising or giving opinions to persons relative to such contracts other than as a consulting actuary advising a prepaid limited health service organization or as a salaried bona fide full-time employee so counseling and advising her or his employer relative to coverage for the employer and her or his employees.

(b) All qualifications, disciplinary provisions, licensing and appointment procedures, fees, and related matters contained in the insurance code which apply to the appointment of health insurance agents by insurers also apply to prepaid limited health service organizations and to persons appointed by prepaid limited health service organizations as their agents.

(c) Examination, licensure, or appointment is not required of any regular salaried officer or employee of a prepaid limited health service organization who devotes substantially all of her or his services to activities other than the solicitation of prepaid limited health service organization contracts from the public and who receives no commission or other compensation directly dependent upon the solicitation of such contracts.

(d) As used in this section, the term "salaried" refers to basic remuneration and does not include commissions, bonuses, or any other compensatory measures.

SECTION 36. Minimum net worth and working capital requirements.

(a) Except as set forth in subsection (c), each prepaid limited health service organization must at all times maintain a minimum net worth and working capital as required pursuant to §56-32-212.

(b) Except as set forth in subsection (c) the department may not issue a certificate of authority unless the prepaid limited health service organization is in compliance with §56-32-212.

(c) Notwithstanding the forgoing, the department is hereby authorized to promulgate rules and regulations pursuant to the provisions of Title 4, Chapter 5 that set forth minimum net worth and working capital requirements for any prepaid limited health service organization that limits the services it offers to services rendered by professional licensed to practice the healing arts and regulated by a single health related board pursuant to Title 63.

SECTION 37. Insolvency protection.

(a) Except as required in subsection (b), each prepaid limited health service organization must deposit with the department cash or securities of the type eligible under §56-32-211 which must have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually or more often as the department deems necessary. The market value of the deposit must be that which is prescribed in §56-32-212(b).

(b)(1) If securities or assets deposited by a prepaid limited health service organization under this act are subject to material fluctuations in market value, the department may in its discretion require the organization to deposit and maintain on deposit additional securities or assets in an amount as may be reasonably necessary to assure that the deposit will at all times have a market value of not less than the amount specified under §56-32-212(b).

(2) If for any reason the market value of assets and securities of a prepaid limited health service organization held on deposit under this act falls below the amount required, the organization must promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency. If the prepaid limited health service organization has failed to cure the deficiency within 30 days after receipt of notice by certified mail from the department, the department may revoke the certificate of authority of the prepaid limited health service organization.

(3) A prepaid limited health service organization may, at its option, deposit assets or securities in an amount exceeding its deposit required or otherwise permitted under this act for the purpose of absorbing fluctuations in the value of securities and assets deposited and to facilitate the exchange and substitution of securities and assets. During the solvency of the prepaid limited health service organization any excess must be released to the organization upon its request. During the insolvency of the prepaid limited health service organization, any excess deposit may be released to the Commissioner as receiver, rehabilitator, or liquidator as provided under Title 56, Chapter 9.

(c) All income from deposits shall be an asset of the organization. A prepaid limited health service organization that has been allowed by the department to make a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value as approved by the department.

SECTION 38. Officers' and employees' fidelity bond.

(a) A prepaid limited health service organization must maintain in force a fidelity bond in its own name on its officers and employees, in an amount not less than $50,000 or in any other amount prescribed by the department. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this State.

(b) In lieu of the bond specified in subsection (a), a prepaid limited health service organization may deposit with the department cash or securities or other investments of the types set forth in Section 34. Such a deposit must be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

SECTION 39. Suspension or revocation of certificate of authority; suspension of enrollment of new subscribers; terms of suspension.

(a) The department may suspend the authority of a prepaid limited health service organization to enroll new subscribers, through its contract with a health maintenance organization or with a federal or state agency, or revoke any certificate issued to a prepaid limited health service organization or order compliance within 30 days, if it finds that any of the following conditions exist:

(1) The organization is not operating in compliance with this act.

(2) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this act.

(3) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(4) The organization is insolvent.

(5) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Sections 7 and 8 of this act, unless amendments to such submissions have been filed with and approved by the department.

(6) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services.

(7) The prepaid limited health service organization has no subscribers 12 months after the issuance of the certificate of authority.

(8) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees.

(b) If the department has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, it shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and shall pursue a hearing on the matter in accordance with the provisions of the Uniform Administrative Procedures Act, Title 4, Chapter 5.

(c) When the certificate of authority of a prepaid limited health service organization is surrendered or revoked, such organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the certificate of authority. It may not engage in any further advertising, solicitation, or renewal of contracts. The department may, by written order, permit such further operation of the organization as it finds to be in the best interest of enrollees, so that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

(d) The department shall, in its order suspending the authority of a prepaid limited health service organization to enroll new subscribers, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the prepaid limited health service organization prior to reinstatement of its authority to enroll new subscribers. The order of suspension is subject to rescission or modification by further order of the department prior to the expiration of the suspension period. Reinstatement may not be made unless requested by the prepaid limited health service organization; however, the department may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

SECTION 40. Administrative penalty in lieu of suspension or revocation.

In lieu of suspending or revoking a certificate of authority, or when no penalty is specifically provided, whenever any prepaid limited health service organization or other person, corporation, partnership, or entity subject to this act has been found to have violated any provision of this act, the department may:

(a) Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of such findings and an order requiring such organization, person, or entity to cease and desist from engaging in the act or practice which constitutes the violation, and

(b) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $100,000.

SECTION 41. Injunction.

In addition to the penalties and other enforcement provisions of this act, the department is vested with the power to seek both temporary and permanent injunctive relief when:

(a) A prepaid limited health service organization is being operated by any person or entity without a certificate of authority.

(b) Any person, entity, or prepaid limited health service organization has engaged in any activity prohibited by this act or any rule adopted pursuant thereto.

(c) Any prepaid limited health service organization, person, or entity is renewing, issuing, or delivering a prepaid limited health services contract without a certificate of authority.

The department's authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to the Uniform Administrative Procedures Act, Title 4, Chapter 5.

SECTION 42. Payment of judgment by prepaid limited health service organization.

Except as otherwise ordered by the court or as mutually agreed upon by the parties, every judgment or decree entered in any court against any prepaid limited health service organization for the recovery of money must be fully satisfied within 60 days after the entry thereof, or, in the case of an appeal from such judgment or decree, within 60 days after the affirmance of the judgment or decree by the appellate court.

SECTION 43. Levy upon deposit limited.

No judgment creditor or other claimant, other than the department, of a prepaid limited health service organization shall have the right to levy upon any of the assets or securities held in this state as a deposit under Section 38.

SECTION 44. Supervision, rehabilitation, conservation, liquidation, or reorganization; exclusive methods of remedy.

(a) A delinquency proceeding under title 56, Chapter 9, Parts 2, 3, or 4 or supervision by the department pursuant to Title 56, Chapter 9, Part 5 constitute the sole and exclusive means of supervising, liquidating, reorganizing, rehabilitating, or conserving a prepaid limited health service organization.

(b) No prepaid limited health service organization is subject to the laws and regulations governing insurance or health maintenance organization insolvency guaranty funds. No insurance insolvency guaranty fund may provide protection to any individuals entitled to receive limited health services from a prepaid limited health service organization for services related to a prepaid limited health service contract.

SECTION 45. Fees.

Every prepaid limited health service organization subject to this act must pay to the department the following fees:

(a) For filing an application for a certificate of authority: $500.

(b) For filing an amendment to organization documents that require approval: $50.

(c) Each annual report: $100.

(d) For each renewal of certificate of authority each year: $100.

SECTION 46. Investigative power of department.

The department has the power to examine and investigate the affairs of every person, entity, or prepaid limited health service organization in order to determine whether the person, entity, or prepaid limited health service organization is operating in accordance with the provisions of this act or has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by §§56-8-103 and 56-8-104. The department also has the powers enumerated in Title 56, Chapter 8.

SECTION 47. Unfair methods of competition, unfair or deceptive acts or practices defined.

For the purposes of defining unfair methods of competition, unfair or deceptive acts or practices, the provisions of §56-8-104 apply to a prepaid limited health service organization.

SECTION 48. Appeals from the department.

Any person, entity, or prepaid limited health service organization subject to an order of the department under this act may obtain judicial review of the order by filing an appeal therefrom in accordance with the provisions and procedures for appeal under the Uniform Administrative Procedures Act, Title 4, Chapter 5.

SECTION 49. Civil liability.

The provisions of this act are cumulative to rights under the general civil and common law, and no action of the department abrogates such rights to damage or other relief in any court.

SECTION 50. Confidentiality.

(a) Any information pertaining to the diagnosis, treatment, or health of any enrollee of a prepaid limited health service organization is confidential and exempt from the provisions of §10-7-503 and shall only be available pursuant to specific written consent of the enrollee, or as otherwise provided by law. With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization is entitled to claim any statutory privileges against disclosure which the provider who furnished such information to the prepaid limited health service organization is entitled to claim.

(b) Any proprietary financial information contained in contracts entered into with providers by prepaid limited health service organizations is confidential and exempt from the provisions of §10-7-503.

(c) Any information obtained or produced by the department pursuant to an examination or investigation is confidential and exempt from the provisions of §10-7-503 until the examination report has been filed and adopted by the Commissioner or until such time, if ever, the information is used in litigation by the Commissioner or in a contested case. Except for active criminal intelligence or criminal investigative information; personal financial and medical information; information that would defame or cause unwarranted damage to the good name or reputation of an individual; information that would impair the safety and financial soundness of the licensee or affiliated party; proprietary financial information; or information that would

reveal the identity of a confidential source, all information obtained by the department pursuant to an examination shall be available after the examination report has been filed.

SECTION 51. Acquisitions.

Each prepaid limited health service organization is subject to the provisions of Title 56, Chapter 11.

SECTION 52. Taxes imposed.

(a) The premiums, contributions and assessments received by prepaid limited health service organizations are subject to the tax imposed by Tennessee Code Annotated, Section 56-32-224.

(b) The department shall administer this section pursuant to Tennessee Code Annotated, Section 56-32-224.

(c) The amount of taxes collected under this section shall be a single credit against the sum total of the taxes imposed by the Franchise Tax Law, compiled in Title 67, Chapter 4, Part 21 and by the Excise Tax Law, compiled in Title 67, Chapter 4, Part 20.

(d) Any entity required to be licensed under this chapter and that was under a contract with the State of Tennessee on June 1, 2000 to provide services to Title XIX Program recipients shall be exempt from the requirements of sub section (a) with regard to premiums, contributions and assessments received under such contract. This exemption shall expire December 31, 2001.

SECTION 53. Rules.

The department has authority to adopt rules to effectuate the provisions of this act. Such rules shall be adopted in accordance with the rulemaking provisions of the Uniform Administrative Procedures Act, compiled at Title 4, Chapter 5. The department may also adopt public necessity rules as determined to be necessary to effectuate the provisions of this act, in accordance with the provisions of the Uniform Administrative Procedures Act. No rule shall be adopted without prior hearing and notice as provided under Title 4, Chapter 5. A violation of any such rule subjects the violator to the provisions of Section 40.

SECTION 54. Provisions of Title 56, Chapter 32 which are specifically applicable to health maintenance organizations which participate in the TennCare Program under Title XIX of the Social Security Act or any successor to the TennCare program shall also be applicable to prepaid limited health service organizations who participate in the TennCare program or any successor program.

SECTION 55. Severability.

If any provision of this act or the application of the provisions to any circumstance is held invalid, the remainder of the capital act or the application of the provision to other circumstances shall not be affected.

SECTION 56. For purposes of rulemaking, this act shall become effective upon becoming law, the public welfare requiring it. Section 37 of this act shall apply upon becoming a

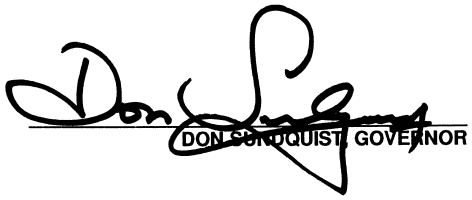
law to any entity required to be licensed under this chapter and under a contract with the State of Tennessee on June 1, 2000 to provide services to Title XIX program recipients.
For all other purposes, this act shall become effective January 1, 2001.

PASSED: June 9, 2000

JIMMY NAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES

JOHN S. WILDER
SPEAKER OF THE SENATE

APPROVED this 23rd day of June 2000



DON SUNDQUIST, GOVERNOR